VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

June 7, 2016

Ms. Gail Kaminski Potter, Manager
Our Lady Of Providence
47 West Spring Street
Winooski, VT 05404-1397

Dear Ms. Kaminski Potter:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 4, 2016.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0198	A. BUILDING: _____ B. WING _____	C 05/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PROVIDENCE	47 WEST SPRING STREET WINOOSKI, VT 05404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite complaint investigation was conducted on 5/2-4/2016 by the Division of Licensing & Protection. The following regulatory deficiencies were identified during the investigation:	R100	Our Lady of Providence submits this Plan of Correction under procedures established under the Vermont Residential Care Home regulations. This Plan of Correction should not be construed as either a waiver of Our Lady of Providence's right to appeal or an admission of past or ongoing violations of regulatory requirements.	
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that the written plan of care was revised to describe the care and services necessary to assist the resident to maintain independence and well-being. (R#1 and R#3) Findings include: 1). Per record review Resident #1 (R#1) used a Rollator (rolling) walker for mobility with staff oversight. In an interview on 5/4/16 at 9:10 AM the RN (registered nurse) charge nurse stated that R#1 often requested that the LNAs (licensed nursing assistants) assist him/her back to his/her room by pushing him/her while seated on the rollator. S/he stated that s/he had never witnessed staff comply with that request. On 2/6/16 the resident was involved in an incident when an LNA was pushing him/her on the rollator and it tipped backwards. Notes following this fall	R145	R145 All residents will have a written plan of care, which describes the care and services necessary to maintain independence and well-being. Professional nursing staff will be in-serviced on adding appropriate interventions as residents' need change. Resident #1, Resident #2, and Resident #3 are deceased. All other residents' care plans will be audited for completeness and accuracy by a designated RN. The DON/NHA will review the 24 hour reports and incident reports daily, and cross reference the care plans to ensure any pertinent items are included. Goal Date: June 30, 2015	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Paul K. Potter Administrator 5/26/16

R145-R227 POC's accepted 6/6/16 MHiggins RN | PMC

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R145	Continued From page 1 reflect that the resident 'hurt all over", "wasn't walking" was "weak and unsteady" and was "weepy". There are no revisions in the care plan to reflect either instructions to direct care staff to use only a wheelchair to transport the resident or regarding the changes in his physical and mental condition. In an interview on 5/4/16 the DNS (Director of Nursing Services) confirmed that the care plans reviewed were only care plans available. 2). Per record review R#3 had exhibited increasing combative behaviors and resistance to care for the several months prior to his/her death. There is no care plan for either the behaviors or the resistance to care in the record. In an interview on 5/4/16 the DNS (Director of Nursing Services) confirmed that the care plans reviewed were only care plans available.	R145		
R150 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken; This REQUIREMENT is not met as evidenced by: Per record review and staff interviews the facility failed to assure that symptoms or signs of an accident are recorded at the time of occurrence, along with action taken for R#2 who exhibited signs of an injury to his/her foot. Findings include: Per record review, Resident #2 was taken to the Dining Room for lunch on 4/1/16, in a	R160	R150 All incidents will be documented on an incident report form. There will also be documentation recorded in the nurses' notes and 24 hour report, indicating any assessment findings and follow-up. All professional nursing staff will be in-serviced. An audit of a sample of incident reports will be conducted quarterly, to insure proper follow-through and documentation in the medical record. This audit will be done by the Health Information Specialist. Goal Date: June 30, 2016	

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R150	Continued From page 2 wheelchair. While s/he was positioned at the table s/he hollered when another resident was wheeled to the table near him/her. S/he indicated that something had happened to his/her foot. In an interview on 5/3/16 the RN charge nurse indicated that s/he was aware of the incident. There were no notes indicating that the resident was assessed for injury or treated for any injury. The absence of documentation was confirmed by the RN charge nurse.	R150		
R213 SS=G	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on staff interview the facility failed to assure that every resident is treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. Findings include: Per staff interview R#2, who was on Hospice, was seated in a wheelchair ready to be transported to the 1st floor main dining room. The staff person offered to assist the direct care staff in taking residents to the dining room and states s/he was directed to take R#2 to the dining room. The staff person acknowledged that as s/he started to move the resident to the dining room the resident began crying and refusing to go to the dining room. Despite the resident's refusal and obvious upset, s/he was moved from the	R213	R213 All staff will be re-informed of the Residents' Rights, with emphasis on the resident's dignity and right to privacy. Any infraction observed or reported and validated will result in discipline, if perpetrated by an employee. Goal Date: June 30, 2016	

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R213	Continued From page 3 second floor to the first floor dining room in the presence of other residents. The resident was upset and placed in a public community area despite the lack of privacy. In an interview on 5/2/16 at 1:15 PM the staff person who had transported this resident confirmed the circumstances of the transport as above.	R213		
R227 SS=G	VI. RESIDENTS' RIGHTS 6.15 Residents have the right to refuse care to the extent allowed by law. This includes the right to discharge himself or herself from the home. The home must fully inform the resident of the consequences of refusing care. If the resident makes a fully informed decision to refuse care, the home must respect that decision and is absolved of further responsibility. If the refusal of care will result in a resident's needs increasing beyond what the home is licensed to provide, or will result in the home being in violation of these regulations, the home may issue the resident a thirty (30) day notice of discharge in accordance with section 5.3.a of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview the facility failed to assure the resident's right to refuse care to the extent allowed by law for Resident #2. Findings include: Per staff interview R#2, who was on Hospice, was seated in a wheelchair ready to be transported to the 1st floor main dining room. The staff person offered to assist the direct care staff in taking residents to the dining room and states s/he was	R227	R227 All staff will be re-informed of the Residents' Rights, especially the right to refuse care. Any infraction observed or reported and validated will result in discipline if perpetrated by an employee. Goal Date: June 30, 2016	

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R227	Continued From page 4 directed to take R#2 to the dining room. The staff person acknowledged that as s/he started to move the resident to the dining room the resident began crying and refusing to go to the dining room. Despite the resident's refusal s/he was moved from the second floor to the first floor dining room until another staff person stated that the resident should be brought back to his/her room. In an interview on 5/2/16 at 1:15 PM the staff person who had transported this resident confirmed the circumstances of the transport as above	R227		